DIABETES ADVISORY COALITION – MEETING MINUTES

January 17, 2014 DoubleTree Missoula

10:00-10:15AM **Introductions** Sarah Brokaw	Everyone introduced themselves and coalition members noted Paul Campbell has been hired as the new Prevention Program Coordinator.
10:15 – 11:15AM **Outcomes from the Montana Cardiovascular Disease & Diabetes Prevention Program** Dorota Carpenedo, MPH	The first of this two part presentation focused on the factors associated with achieving a weight loss goal among Medicaid and Non-Medicaid DPP Participants. **Background:** With no intervention the majority of people with pre-diabetes will develop T2 diabetes and people with pre-diabetes who make modest lifestyle changes will significantly reduce their risk of developing T2 diabetes. A brief review of the National DPP and eligibility criteria was followed by a slide showing the 18 sites within Montana. The goal of the Medicaid Incentives Grant is to increase participation of adults enrolled in Medicaid in the DPP, test the use of incentives to increase participation, behavior change and weight loss goal achievement. **Study Objectives:** Assess feasibility to recruit Medicaid beneficiaries and evaluate weight loss outcomes of Medicaid compared to non-Medicaid. **Data Analysis:** Used were intent to treat using last recorded values, Chi-square statistics for categorical variables, T-test statistics test for continuous variables and multiple logistic regression to identify variables independently associated with achieving the weight loss. **Results:** 14 sites Fall 2012 – Spring 2013, 983 participants enrolled, 118 (12%) enrolled in Medicaid; 865(88%) non-Medicaid. At 5 years goal is 724 Medicaid participants, but 300 will be more realistic. Medicaid participants on average are 9 years younger, gender about the same 74-80% female, 20-26% male. Both groups attended about 11 to 12 sessions. Medicaid lost 7 lbs from baseline, non-Medicaid lost 11 lbs. The graph shows several bumps; hoping to better understand why. Could be seasonality, holidays or monthly use of SNAP benefits. 59% of Medicaid and 47% of non-Medicaid participants achieved the physical activity goal. Medicaid participants recording their weekly fat intake for fewer weeks than non-Medicaid. Factors independently associated with achieving the 5% and 7% weight goal are age, and group (Medicaid vs. non-Medicaid). Older participants 2 times more likely to achieve the 7% weight loss goal than younger enrollees 18-44 years. Medicaid 2 times less likely to achieve the 7% weight loss goal. Baseline BMI and gender didn't make a difference on achievement of weight loss goal. **Limitations:** Small sample, self-reported and incomplete data. **Suggestions:** Interested in results for people who are on medications that can cause weight gain and results for people with disabilities. Want to look at linking Medicaid participants and claims data and the disability. Could literacy be a the reason they drop out? We need to know the barriers and hopefully develop tools to share sooner rather than later. What is their family life like? Families and children in home will make a difference. Incentives are sent out about a week and a half after they have earned them. If they attend each week they should be getting something each week. Chose cash based upon previous studies that concluded people liked cash best as an incentive. What about a timed incentive for the last ½ of month when other benefits like SNAP have run out, and they can use incentive payment to purchase healthy foods last ½ of month. Helping participants build a budget to use incentives or income would be a good tool. Sample budget-friendly grocery list would be helpful. Make sure you encourage them to go to the food banks. **Implications:** Attainable weight loss levels. Healthy diet, exercise, and weight loss lowers triglycerides, cholesterol and blood pressure in overweight and obese persons. **Conclusions:** It is feasible to recruit and retain adult Medicaid beneficiaries into an adapted DPP and achieve significant, but somewhat less, weight loss compared to non-Medicaid participants.

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	2nd part What are the challenges and solutions to delivering the DPP to Medicaid beneficiaries? **Survey Objective**: Assess challenges and identify solutions to deliver the DPP to adults enrolled in Medicaid. **Methods:** Qualitative assessment, emailed to lifestyle coaches in Oct. Reminders sent and during face to face meeting. 100% response rate. **Results:** 71% very/somehow difficult to recruit Medicaid beneficiaries. Barriers to participation: commitment to follow through with enrollment and attending initial sessions, transportation. Curriculum works well 19%; 71% somewhat well, 10% not well. Sessions tend to be too complex too much information. What did participants find challenging? Documenting fat intake and physical activity. **Suggestions:** Has anyone in the group used tracking tools that are simpler? Food groups check box tool is one example. Identify the high risk foods. Give themselves a reward for not having the bad food. Self-monitoring is individual and each participant will have a different preference (e.g., written tracking booklet, app, checkboxes, photos, diagrams). Myrna will send out a request for simpler tracking tools to the national listserv for QIOs. One barrier to participating in the DPP is that it is only offered 1 or 2 times a year in each location. Implementing the DPP as a lifestyle coach is challenging and the work load is exhausting. We need to focus on preventing health coach burnout. Nancy agreed. They need to be engaged. Colleen has volunteer doing data entry. Lisa likes to see the participants pair up. Paul suggested taking class outside when possible. What about trouble with referrals at Barrett Hospital & HealthCare in Dillon due to fat gram tracking? In April, only 5 participants. Now they are doing better and the provider felt badly about the effect the program, so we will monitor to see how it goes. MT Community First Choice Person-Centered Planning Process – Waiver expansion.
11:15 – 11:30AM	Break
11:30 – 12:20PM **CDC "1305" Grant Workplan Overview** Sarah Brokaw, MPH	The **1305 CDC Grant** funds Nutrition and Physical Activity, Diabetes, Cardiovascular Health and School Health (OPI). It was submitted last spring, received award notice in June 2013 and permission to spend in December 2013. The work plan is by domains. Domain 2 covers nutrition, physical activity, school health and worksite health promotion. Domain 3 covers health systems and quality improvement. Domain 4 covers community-clinical linkages, DSME, DPP, CHRs and school health. Evaluation Plan-performance measures include short term, intermediate, and long term. It is a 5 year project period. Health Systems Projects include EHRSs and Health IT, team based care, QI processes, and DQCMS. For **Health Systems**, Sarah explained each performance measure, data source, the baseline number, what year 1 target is and what year 5 target will be. There was some discussion on how to effectively report the information back that CDC is requiring. For **Community Clinical** Projects the discussion began with DSME and its measures. Used to have 2 recognized DSME programs now have 28, which doesn't include IHS sites except for Rocky Boy which is accredited by AADE. DSME vastly underused benefit for Medicare pts. It was noted that DSME is not, under the Affordable Care Act exchanges in Montana a Essential Health Benefit. Based on the smallest group coverage in the state. Marci will start making calls to see what a process would be to see if DSME can be covered under EHD. Maybe contact Monica Lindeen. DSME may be covered under Chronic Disease. Obama care policies will not allow G codes.

	Nurses can't use Medical Nutrition Therapy code, only dietitians. The discussion had to close as we were running very late. These subjects will be brought to the table again.
12:20PM – 1:00PM	Lunch
1:00-1:30PM **Investigating Hospitalization Data for People with Diabetes** Dorota Carpenedo, MPH and Marci Butcher, RD, CDE	The report of the **Montana Prevention Quality Indicators**. Our programs have been receiving hospital discharge data for 4 years. Extensive analysis must be done in conjunction. Currently, we can't find out readmissions rates because the data are de-identified. Can't disclose information by hospital, but can compare regions and counties. We can look at age at time of admission, source of admission ie ER, nursing facility. Can look at payors. Primary diagnosis and up to 8 secondary diagnoses. Most admissions due to complications but not generally admitted because of diabetes. Also, hospitals may code to how they will get reimbursed. ICD9 codes are included in the data set. We have a lot to learn from the hospitalization data, so want to show you what data we have, and see what you may be interested in looking at in more detail. From preliminary analysis by OEES, it doesn't appear there were more admissions at the end of the month than at the beginning. Multiple places they could have come to the hospital admitting from. **Actions**: Read MT Prevention Quality Indicators 2000-2009 report and see what is there. We want to pull useful information, and ask the right questions for the data we have access to. Think of questions or implications of the data and send questions to Sarah. Can we tell if patients leave the state? Nancy thought amputations related to diabetes have been trending downward. Is there a way to get data on how many people are getting DSME? For Patient Centered Medical Home, DSME is a driver for care. Secondary dx useful to understand disability.
1:30 – 1:45PM Conference	**Evaluations** enclosed, and overall positive feedback. **Planning the next year**. Hypertension/CVH as well as diabetes topics will be presented. Let Sarah or Susan know of some ideas for speakers or topics. Some ideas for speakers include Peter Chase on T1 Pediatric Care, Bob Gabbay from Joslin on PCMH and primary care, Victor Montori on evidence-based medicine and clinical decision making plus using tools to see if pts are adhering to medications, and Hope Warshaw on nutrition and behavior change.
1:45 – 2:00P Break	
2:00 – 2:40PM **CMS Quality Improvement Organization 11th Scope of Work: Diabetes Care** Janice Mackensen and Myrna Seno, Mountain Pacific Quality Health Foundation (MPQHF)	**CMS 11th Scope of Work** includes under goal 1 Promoting Effective Prevention and treatment of Chronic Disease, Task B2 Reducing Disparities in Diabetes Care. 5-year project period. Design a workable response to RFP. Need for people with diabetes to have increased access to DSME. Need providers to participate in this with referrals. Trying to coordinate and align the work that MPQHF will do for CMS and what DPHHS does for CDC. Align with what is happening for DSME to enhance the success that Montana could overall see. **Some goals:** Increase adherence to guidelines. DSME is a proven intervention for

	people with diabetes. A shared goal is coordination of care. Look at Medicare and dual eligible members. Developing, implementing and operationalizing sustainability plan. **Need** more educators and DSME programs. Rural areas are lacking in educators. Outreach clinics go far for diabetes education. Need referrals from primary care providers. Also need to encourage the patient to talk to the educator. Some issues on referrals: time between referral and DSME visit, plus clients don't volunteer to go to DSME. Need to help clients understand educators are there to help them. Patients may say they know all they need to know. It could feel like going "to the principal's office" as a punishment for not self-managing properly. Then patients say that DSME was so much better than what they thought. Challenge with participation is no-show rate: 20% no show/cancel rate at St. Peters. A good message would be to use the health care benefits you have. Need marketing plan for Primary care providers? What about possibly offering credit to students as workforce development. Reimbursement is still only $250 for 1 ½ hours of DSME. **CDEs**: Criteria for CDE have changed. 1,000 hours in 4 years to sit for exam. Now can use volunteer hours. Rural areas have not got the volume to get the hours. Work with providers and Community Health Workers. A CHW could lead support groups. Some states said there was a community group that did classes for people on referral general classes like goal setting for people who didn't have just the basic help with everyday skills to improve your life and health. **Encouraging participation**: Joel, how do you get people with diabetes who are referred but not engaged in DSME? It can be embarrassing when you don't do self-management correctly. Need to get beyond the past and concentrate on now/future: it's not about yesterday, it's about tomorrow. Messaging could be to delay and prevent complications, and take diabetes seriously. This is what can happen to you, yet put a positive twist on it. Focusing on small changes and maybe nutrition. Speak to it and move to change. Self-engage people. Taking a vested interest in them. If significantly overweight, encourage them to the path of health. Referral needs to grab you. Health coaches who will help you work on what we have talked about. For physicians way for them to refocus and show they care. Flyers from AADE try to make DSME look like a positive thing. Identify opportunities for you. Welcome to Medicare diabetes education coupon, which includes 1st exam and a diabetes education coupon. **Increase access**: Help those organizations be satellite sites to the recognized programs. Billings oversight to (Lauri Uphaus example) or maybe tele-health.
2:55 – 3:00PM **Closing**	**Next meeting** can discuss School health topics, Monica Lindeen, MT Hospital Discharge, Data System updates, recognition of those who have still been on the committee. Looked at the **fact sheet** on what our coalition does. Does this description accurately reflect who we are? Asked for ideas or suggestions for coalition members to fill in any gaps in membership, such as AI/AN liaison. Decided no need for Coalition by-laws.

Present: Susan Day, Sarah Brokaw, Chris Jacoby, Paul Campbell, Dorota Carpenedo, Lisa Ranes, Kathy Rucker, Nancy Eyler, Joel Peden, Heather Sauro, Brenda Bodner, Catherine Addison, Paula Block, Janice Mackenson, Myrna Seno, Meg Traci, Colleen Karper, Gayle Hudgins, Dorothy Velk